

all as a result of concerns about confidentiality. All these patients have documented their decision in writing. One patient offered to make a contribution to the costs if it was possible to continue on hospital prescriptions, but there is at present no logistical method for achieving this. Of the 63 general practitioners contacted, four refused to prescribe the recommended aciclovir treatment, predominantly citing the grounds of costs or not wishing to accept responsibility for the care. Overall, 59 patients were successfully referred to their general practitioners who continued to prescribe the recommended dosages of aciclovir. This did not reduce the frequency of visits to the genitourinary medicine clinic as continued monitoring of the therapy, ongoing support, and counselling and discussion on when to cease therapy were carried out in the clinic according to our protocol.

Our experience suggests that the overwhelming majority of patients are prepared to give permission for the involvement of the general practitioner in the management of their genital herpes and that the majority of general practitioners are pleased to cooperate clinically in this management. All newly diagnosed patients with genital herpes are now being directly asked for their permission to involve their general practitioner in their care and we will continue to audit our experience of the uptake of this. A small proportion of patients continue on hospital prescriptions because of their concern about confidentiality.

BARBARA VONAU
SIMON E BARTON
BRIAN G GAZZARD

Department of HIV/Genitourinary Medicine,
St Stephen's Centre,
Chelsea and Westminster Hospital,
369 Fulham Road, London SW10 9NH

Correspondence to: Dr Barbara Vonau.

- 1 The Herpes Simplex Virus Advisory Panel. Sharing care in genital herpes—new guidelines for the GP/GUM interface. *Br J Sex Med* 1996;May/June:13–5.

Accepted for publication 17 February 1997

Hypospadias associated with the use of high dose megestrol acetate in an HIV infected woman

Megestrol acetate has been used to stimulate appetite and promote weight gain in patients with acquired immunodeficiency syndrome (AIDS) related cachexia and wasting.^{1,2} We report a case of hypospadias associated with the use of high dose megestrol acetate during the first trimester of pregnancy.

Hypospadias is a congenital malformation, in which the urethral meatus forms proximal to its normal position, resulting from incomplete fusion of the urethral groove during fetal development.³ (The normal process of fusion is brought about by androgens from the fetal testes during the first trimester of pregnancy.) Hypospadias is a relatively common abnormality, with a prevalence ranging from 1 in 300 to 1 in 1000 male births in the general population.^{4,5}

Synthetic progestogens have been suggested as possible low risk teratogens for a range of congenital abnormalities.^{6,7} While the association of hypospadias with the use of standard doses of synthetic progestogens during pregnancy has been described,⁸ there have been no reports to date of birth

defects associated with the use of high dose megestrol acetate.

Thirty women with human immunodeficiency virus (HIV) infection, and more than 10% weight loss, were enrolled in a study of weight gain using an oral suspension of megestrol acetate. Patients were randomised to receive either 400 mg or 800 mg of megestrol acetate per day for 24 weeks. A 28 year old HIV positive female participated in the study with the following chronology of events. At enrolment, she had had surgery 2 months earlier for an ectopic pregnancy with irregular menses, and her initial serum pregnancy test was negative. She was counselled regarding the necessity of using barrier method contraception. She started taking megestrol acetate but failed to attend for follow up clinic visits. Subsequently, pregnancy testing and ultrasonography demonstrated that she was 17 (SD 2) weeks pregnant. It was determined retrospectively that she had taken megestrol acetate, 400 mg per day, for 18 days from the 4th to the 7th week of pregnancy (by ultrasound dates). Her only other medication was zidovudine, 600 mg per day. At 38 weeks' gestation, she delivered by repeat caesarean section a live male infant, with normal Apgar scores, weighing 2633 g, with second degree hypospadias. The boy, now 7 months old and HIV negative, will require corrective surgery.

High doses of megestrol acetate in the first trimester of pregnancy may increase the risk of hypospadias. This warning appears in the drug manufacturer's prescribing information.⁹ Caution needs to be exercised in prescribing megestrol acetate to HIV infected women with reproductive potential. Repeated counselling of patients on the use of adequate contraception and education of staff and patients regarding potential teratogenic effects of megestrol acetate should be stressed.

DAVID J FARRAR
IRENE AROMIN
SUSAN CU UVIN
TIMOTHY P FLANIGAN
MARIA D MILENO
Department of Medicine,
The Miriam Hospital,
Brown University School of Medicine,
Providence, Rhode Island, USA

Correspondence to: Dr M D Mileno, Immunology Center, The Miriam Hospital, 164 Summit Avenue, Providence, RI 02906, USA.

- 1 Von Roenn JH, Armstrong D, Kotler DP, Cohn DL, Klimas NG, Tchekmedyan NS, et al. Megestrol acetate in patients with AIDS-related cachexia. *Ann Intern Med* 1994; 121:393–9.
- 2 Oster MH, Enders SR, Samuels SJ, Cone LA, Hooton TM, Browder HP, et al. Megestrol acetate in patients with AIDS and cachexia. *Ann Intern Med* 1994;121:400–8.
- 3 Stock JA, Scherz HC, Kaplan GW. Distal hypospadias. *Urol Clin N Am* 1995;22:131–8.
- 4 Dawson C, Whitfield H. ABC of urology: common paediatric problems. *BMJ* 1996;312: 1291–4.
- 5 Aarskog D. Maternal progestins as a possible cause of hypospadias. *N Engl J Med* 1979; 300:75–8.
- 6 Katz Z, Lancet M, Skornik J, Chemke J, Mogilner BM, Klinberg M. Teratogenicity of progestogens given during the first trimester of pregnancy. *Obstet Gynecol* 1985;65: 775–80.
- 7 Darling MR, Hawkins DF. Sex hormones in pregnancy. *Clin Obstet Gynecol* 1981;8: 405–19.
- 8 Allen TD, Griffin JE. Endocrine studies in patients with advanced hypospadias. *J Urol* 1984;131:310–4.
- 9 Megestrol acetate (Megace) product labelling and package insert.

Accepted for publication 3 March 1997

Lymphoedema of the genitalia secondary to skin tuberculosis: report of three cases

Lymphoedema of the genitalia due to lymphatic obstruction is generally caused by filariasis, at times by neoplastic changes, and rarely, by lymphogranuloma venereum or donovanosis.¹ We report its unusual occurrence in two patients with scrofuloderma and one with lupus vulgaris.

Case reports

CASE NO 1

A 25 year old woman with a 15 year history of recurrent swellings in the neck and groins had taken indigenous treatment with no relief. Later she had swelling of the vulva which brought her to the hospital. Examination revealed irregular scarring and few intermittently discharging sinuses over the submandibular and cervical areas. Multiple abscesses and sinuses were seen affecting the inguinal lymph nodes of both sides. The soft and swollen vulva showed vesicles, some of which had eroded. Systemic examination revealed no abnormality.

Investigations revealed a haemoglobin of 10 g/dl, white cell count $10.4 \times 10^9/l$, differential—polymorphs 50, lymphocytes 34, eosinophils 26, erythrocyte sedimentation rate 40 mm in the first hour. The enzyme linked immunosorbent assay to detect HIV was negative. Mantoux test to 0.1 ml of purified tuberculin (Span Diagnostics, Surat, India) injected on the volar surface of forearm read 40 mm \times 40 mm after 72 hours. \times Rays of the chest and pelvis disclosed no abnormality. Biopsy from an active lesion was sent for histopathology and culture in Lowenstein-Jensen medium. The former revealed a thinned and ulcerated epidermis. In the dermis an acute inflammatory infiltrate was seen around a necrotic area. The deeper dermis showed few tuberculoid structures with epithelioid and occasional Langerhans giant cells surrounded by lymphocytes. No acid fast bacilli were demonstrable in Ziehl-Neelsen stained sections. *Mycobacterium tuberculosis* was isolated on culture. Oral antitubercular treatment (ATT) comprising rifampicin 450 mg/day, 300 mg/day and pyrazinamide 750 mg twice daily was started. Significant improvement was seen after 2 months; pyrazinamide was stopped and the first two were continued. After 3 months the vulval swelling had decreased. She was advised to continue regular treatment but did not report to the hospital again.

CASE NO 2

A 30 year old beggar had occasionally discharging inguinal lesions of 10 years' duration. They had started on the right side and spread over a period of time. There was no history of pulmonary tuberculosis. He had later noticed an increase in scrotal size. Examination revealed fluctuant areas and partially healed sinuses involving the inguinal lymph nodes of both sides. Healed areas were connected by thick scars extending into the suprapubic area. There was scanty to moderate discharge from the sinuses. The scrotum and penile skin were stretched and oedematous (fig). The perianal region appeared normal.

Routine blood and urinalysis, and \times rays of the chest and pelvic area were within nor-